Seizure Care Plan

A physician should complete the information on this page.
A parent should complete page 2.

Student Information:

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

Parent/Guardian Information:

Parent/Guardian #1			Parent/Guardian #2		
Legal Last Name:	Legal First Name:	MI:	Legal Last Name:	Legal First Name:	MI:
Phone #1:	Phone #2:		Phone #1:	Phone #2:	

Type of Seizures:

☐ Absence – staring and decrease in responsiveness ☐ Simple partial seizures ☐ Complex partial seizures
☐ Generalized tonic-clonic seizures ☐ Tonic Seizures ☐ Drop (atonic) seizures ☐ Other (Specify) ______________

Seizure Information:

Date of Last Seizure: ______________________ **Length of Typical Seizure:** ________________________

Describe Typical Seizure: ____
Frequency of Seizures: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other (Specify) ____________________________

Possible Triggers: ____

Student's Response After Seizure: ____

First Aid Procedure:

1. Note time the seizure begins and ends.
2. Provide a safe environment for student. Loosen tight clothing, and turn on side, if able.
3. Designate someone to notify Health Services.
4. Designate someone to notify parents.
5. Stay with student until they have recovered. Talk with him/her. (Do not place anything in student's mouth.)
6. **If seizure lasts more than 5 minutes** or **back-to-back seizures occur**, designate an adult to **call 9-1-1**.
7. If seizure is less than 5 minutes, but there is **difficulty breathing,** designate an adult to **call 9-1-1**.
8. Assure student that everything is alright. Stay with student until they have recovered.
9. Allow student to rest after seizure.

Emergency Response:

A seizure emergency for this student is defined as:	**Seizure Emergency Protocol** • Administer emergency medications as indicated below, for seizures lasting greater than ________ minutes. • Call 911 when emergency medications are administered or if student is having difficulty breathing. • Notify parent or emergency contact.

Medications: include daily and emergency

Emerg. Med ✔	Medication	Dosages & Time of Day Given	Common Side Effects & Special Instructions

Does child have a Vagus Nerve Stimulator (VNS) ☐ Yes ☐ No
Instructions for VNS: ____

Physician's Authorization: I authorize the above plan to be followed at school

Physician's Printed Name:	Signature:	Date:

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

FIELD TRIPS:
- Send a copy of the Seizure Action Plan.
- If supplied by parent, emergency medication will be sent along on the field trip to be used by 911 personnel or by a staff person who has been trained by the Licensed School Nurse/RN, and delegated to administer the medication.

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick up the medication(s) from the office.

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature ____ Date ______________________

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature __________________________________ Date ___________________________

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at anytime in writing, and expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: